In the Matter Of:

STEVEN POLING, No. 354-705

-v-

GARY D. MAYNARD, ET AL.

MARK BUCHANAN, M.D.

April 10, 2015

EXHIBIT 7

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MARYLAND

SOUTHERN DIVISION

STEVEN POLING, #354-705, Plaintiff VS. GARY D. MAYNARD, ET AL, Defendant	CIVIL ACTION #: RWT-12-CV454 HARTFORD, CONNECTICUT APRIL 10, 2015 11:00 A.M. Pages: 1 - 96

DEPOSITION OF MARK BUCHANAN, M.D.

Deposition of MARK BUCHANAN, M.D., taken on behalf of the plaintiff herein, for the purpose of discovery and for use as evidence in this cause, pending in the United States District Court, District of Maryland, pursuant to notice before Vanessa Rose, Lic. No. 212, and Notary Public within and for the State of Connecticut, at the office of REGUS, 100 Pearl Street, Hartford, Connecticut, on April 10, 2015, at which time counsel appeared as hereinbefore set forth.

Reported by: Vanessa Rose Job No. WDC-030409

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(ORIGINAL EXHIBITS ATTACHED TO DEPOSITION TRANSCRIPT)

THEREUPON,

MARK CRAWFORD BUCHANAN, M.D.,

704 Cherry Brook Road, Canton, Connecticut, 06019,

first having been duly sworn, was examined

and testified as follows:

DIRECT EXAMINATION

BY MR. WELLS:

Q. Dr. Buchanan, good morning again.

A. How do you do?

Q. Fine. We were introduced briefly off the record so let's do this on the record. My name is Greg Wells. With me is Andrew Hall and we represent the plaintiff Steven Poling in the case he's brought against, among others, Wexford Health Sources, Inc. As you know we're here to take your deposition today. We want to try to get to this as efficiently as we can. I assume you've had your deposition taken before?

A. I have.

Q. On approximately how many occasions, sir?

A. Somewhere between five and ten.

Q. Okay. I'm going to ask you about, something about those previous depositions in a moment, but let me just get a couple things out.

First and foremost, as we go through this deposition if I ask you any question that you do not understand, please

stop me and let me know that and I'll do what I can to fix whatever the problem is with my question, okay?

A. Yes.

Q. Secondly, this is not a memory contest, so at any time you need to look at any document in order to answer a question, feel free to do so. We would just ask you identify for us on the record what it is that you are referring to when you answer the question, all right?

A. I understand.

Q. Okay. You told me that you had given five to ten depositions before. Were they depositions in cases involving issues similar to those you've been asked to address in this case?

A. Yes.

Q. Okay. How many depositions have you given before where you were asked to address issues similar to those involved in this case?

A. Most of those five to ten depositions would have been in similar cases.

Q. Have you ever given a deposition on behalf of or in support of a defense of Wexford Health Sources, Inc. in the past?

A. No.

Q. Have you ever given a deposition in defense of or supporting the defense of Corizon Medical Services or

A. I did notice it, yes.
Q. And on some occasions you noted where Corizon has indicated it made a request for certain type of specialty care and you saw nothing in the Wexford screenshots that reflected that, correct?
A. Restate that, please.
Q. Sure. There are occasions which, in the Answers to Interrogatories by Corizon, where we find requests for services made for Mr. Poling that are not reflected in the Wexford records, correct?
A. This is in addition to that request made in July, or allegedly made in July?
Q. Yes.
A. In addition to that, yes, there were some referrals made in which the Corizon record, which included the written referral form, asked for one particular service and the screenshots coming out of the UR firm reflected a discussion around the service that was eventually approved after the collegial conversation.
Q. All right. We'll come back to that in the specific request. Where you saw a conflict between what Corizon represented as a request that it made and what you noted as requests from the Wexford records, did you take it as your role to resovle the conflict between the two?
MS. SMITH: Let me just object to form. You

can answer, Doctor.
A. I did not see myself as an investigator here but simply as one who is reviewing the records. I do tend to trust records that are created contemporaneously with a conversation. So I did not think that I could say exactly what had or had not happened. All I knew was what was documented in those utilization review records.
Q. And are you taking the position then that what you have reviewed and assuming it as the documentation of the conversations as complete documentation of the conversations?
A. I assumed that none of the documentation was a complete description of the conversations. I'm sure that these conversations went on for some time and it's simply not practical to record every word that was spoken.
Q. So the first, going down what you've delineated here as a request for outside services as described in the Wexford records on page two, the first one you have is the April 28, 2011 which you listed as a request for outside orthopedic evaluation, correct?
A. Correct.
Q. Did you actually review the consultation form or the request that was actually written by the front-line provider?
A. Yes. I believe I did.

Sorry. We're getting some extra sounds, but go ahead.
Q. Sorry. Can we agree that at the time Dr. Smith, at the time Dr. Smith acted on this request of April 28th, 2011 that the actual request was for exam, evaluate, and possible biopsy of neck mass?
A. That is correct.
Q. And can we also agree that the screenshot from that particular review that you're relying upon makes no mention of a neck mass or evaluation, evaluate or possible biopsy of a neck mass whatsoever?
A. That is correct.
Q. Did you have any concern about the accuracy then, Doctor, of that screenshot in terms of what was requested for this patient and why?
A. Well, I note that it did not fully reflect everything that was on the written note prepared by the Corizon staff.
Q. Whose responsibility was it to make sure that this note accurately reflected what was presented by the Corizon staff?
A. Well, I think what's more important is to document --
Q. Doctor, answer my question, please.
MS. SMITH: He is answering your question,

Greg. You can't just interrupt him. Let him --
MR. WELLS: He has not answered my question. Madam Reporter, would you read my question back?
(Whereupon, the question was read back.)
MS. SMITH: Let me just object to form. You can answer, Doctor.
A. The information addressed at collegial is not fully available to us, but I have confidence in looking at the decision that the important parts of the presentation were incorporated into the decision. Can I explain why that is?
MR. WELLS: Madam Reporter, would you read my question back again, please?
(Read back.
MS. SMITH: Same objection. Asked and answered.
THE WITNESS: Let me take another run at this. The information provided by the Corizon staff certainly was on file at Wexford, but I do not believe was essential to the proper completion of the collegial. Hence, I'm saying that Wexford did not have a responsibility to slavishly copy everything that was in the referral note.
BY MR. WELLS:
Q. Did Wexford have an obligation to make sure the referral note was accurate?

time further trial of non-interventional, non-operative treatment such as physical therapy was indicated, and if I'm not mistaken that actually did cause some improvement.

Q. What information are you assuming Dr. Smith had at the time he denied this request in August 2011 for a neurology consultation made by P.A. Staub?

A. We see from the Wexford information that he had left sided neck pain with radiculopathy going to the right upper extremity.

Q. All right. And are you assuming for purposes of this review that Dr. Smith consulted at the time that there was a collegial discussion?

A. Yes, I am.

Q. And are you assuming that the collegial discussion involved P.A. Staub?

A. Yes.

Q. Are you also assuming that P.A. Staub relayed to Dr. Smith what she had written in her consultation request?

A. I cannot judge that.

Q. Why not?

A. I wasn't there.

Q. Did you read her deposition where she says she typically reads what she wrote?

A. Okay, fine. That is her deposition.

Q. All right. Are you willing to assume that P.A. Staub read to Dr. Smith what she wrote in her consultation report to support her request for this neurology evaluation?

A. If I may --

MS. SMITH: Objection.

THE WITNESS: If I may briefly consult the deposition of Dr. Smith. I've lost my roadmap. Where is that list of everything I brought here? Nevermind. I found Smith here, if I could just refer to that. Can anybody point me to that to speed me up?

BY MR. WELLS:

Q. I was asking you about the physician's assistant Emily Staub.

A. No. I will take your word for what she said at deposition. I'm just looking to see what Dr. Smith said about this.

I do not see a statement specifically from Dr. Smith about the content of that review.

Q. So what does that mean to you, that you're not willing to assume that P.A. Staub presented to him what she had written as she says she typically does?

MS. SMITH: I'm just going to object to the characterization of P.A. Staub's testimony.

A. I would say that I do not have outside data points by which I can judge the accuracy of her testimony.

Q. Did you review the screenshots that you're relying upon against this consultation note to see whether or not the screenshot information accurately reflected the consultation request written by P.A. Staub?

A. I did compare the two and I noted that they, there was some information written by P.A. Staub that did not find its way into the screenshots.

Q. And what information was that?

A. Let me just check that.

What I see missing here is any doc -- from the screenshot -- is documentation of what was found on neurologic exam.

Q. That's important stuff, isn't it?

A. Neurologic examination is important, correct.

Q. It's very important in this case because P.A. Staub is concerned about a neurologic disorder, isn't she, or potential for one?

A. She does seem to be.

Q. And that would be reasonable thinking based on what she's written in her consultation report, correct?

A. I'm sorry?

MS. SMITH: Just object. You can answer.

BY MR. WELLS:

Q. And we can agree that that would be reasonable for her to think, based on what she's written in her consultation report, that there is a potential for a neurologic disorder in this patient?

A. That was a reasonable thought, yes.

Q. All right. And in reviewing her consultation report would you agree with me that this patient had a neurological deficit?

A. I cannot agree with you.

Q. Why not?

A. Because I believe this weakness that she mentioned was at best equivocal, and I say that because some months down the line when he was seen by a physiatry specialist who has a great deal of training in neurology, that man was not convinced that this was a significant loss or may have been related to lack of full effort.

Q. Can we agree that at the time that Dr. Smith acted on this particular request he didn't have this subsequent examination by the physiatrist?

A. We can agree on that.

Q. And if we assume that the clinical information that he had at the time he acted on P.A. Staub's request for neurology consultation on August 22, 2011 was that which was contained in her note, can we agree that he had clinical information that suggested this patient had neurological deficit?

A. If we assume that this information was presented verbally at that meeting then he had information that there might be a neurologic deficit.

Q. All right. And as an internal medicine practitioner would Dr. Smith be obligated to approve a test that would rule in or rule out a neurological disorder in this patient?

MS. SMITH: Let me just object. You're asking not in the UM position role?

MR. WELLS: Same credentials as he has.

MS. SMITH: Well, I'm asking.

MR. WELLS: I'm asking my question.

MS. SMITH: You can answer, Doctor.

A. Could you restate it, please?

MR. WELLS: Madam Reporter, would you read that back, please?

(Whereupon, the question was read back.)

THE WITNESS: The answer is no.

BY MR. WELLS:

Q. Why not?

A. I will tell you that every week in my practice I see patients who may or may not have a neurologic disorder and I do not do a definitive test.

Q. Is that the entire basis for your answer?

A. If you would like examples I'd be happy to give them.

Q. I don't care about examples of what you just said, but I want to make sure that's the entire basis of your answer.

A. The answer to the question that you just asked?

Q. Yes, sir.

A. Yes, that's it.

Q. So, if we assume that Dr. Smith was provided with the information in his consultation note prepared by P.A. Staub, Dr. Smith would have learned that Mr. Poling had pain in the left side of his neck that shot down his left arm, correct?

A. Correct.

Q. He would have learned that Mr. Poling had daily headaches as well, correct?

A. Yes, he would have learned that.

Q. He would have learned that the pain was constant?

A. Correct.

Q. He would have learned that the pain was sharp?

A. Correct.

Q. He would have learned that this patient was kicked in the back of the head and neck three years ago?

A. Correct.

Q. He would have learned that the patient reported numbness and tingling in his left arm?

A. Correct.

Q. He would have learned that that numbness and tingling in the left arm was constant?

A. Correct.

Q. He would have learned that he reported weakness in his left arm?

A. Correct.

Q. He would have learned that he had decreased grip strength?

A. Correct.

Q. He would have learned that the patient used one arm to dress, shower, and feed himself because of the pain and weakness in his arm, correct?

A. Correct.

Q. He also would have learned that the physician assistant's exam documented decreased muscle strength on the left upper extremity?

A. That's correct.

Q. He would have learned that the physician assistant's exam also documented the patient was unable to fan his third, fourth, and fifth fingers in the left hand, correct?

A. That's correct.

Q. He also would have learned that the patient had decreased sensation on the left when compared to the right?

A. That's correct.

Q. Would you agree with me that headaches with abnormal neurological exam suggest a serious underlying disorder?

MS. SMITH: Objection.

A. Not necessarily.

Q. Do you know how brain tumors present typically, what the literature says about it?

A. That depends on the brain tumor, but of course.

Q. Would you agree with me that brain tumors usually present in one of three ways: subacute progression of a focal neurologic deficit, seizure, or non-focal neurologic disorder such as headache?

A. That covers the waterfront, yes.

Q. Do you know whether or not trauma to the back of the head or the neck is associated with meningioma?

A. I have not heard of such an association.

Q. You did see in Dr. Smith's deposition that to him a patient with headaches, neck pain, and arm numbness would be a patient for whom an MRI of the brain was in order?

MS. SMITH: I'm going to object, characterization of Dr. Smith's testimony.

A. As I recall Dr. Smith was answering a highly hypothetical situation in which he was not asked for any of the details, for instance, of the headache.

Q. Would you agree with me that a patient who presents with headaches, neck pain, and left arm numbness is a patient

Q. So the physicians and other healthcare providers that you were responsible for supervising and training, et cetera, were those healthcare providers actual hands-on people in the jail and prison facilities?

A. Yes.

Q. What percentage of your time during the time you were the Director of Medical Services for Correctional Managed Health Care at the University of Connecticut did you spend doing hands-on clinical care in any jail or prison facility?

A. No more than five percent.

Q. And you were, you held this position as Director of the Medical Services for Correctional Managed Health Care for about ten years, 2002 to 2012, correct?

A. That's correct.

Q. And can you tell me the time that you spent doing hands-on clinical care in the jail or prison facilities, was that closer towards the beginning of your tenure, the middle, towards the end or --

A. I would say it was equally spread out.

Q. So you would have provided hands-on clinical care to some inmate in a prison or jail sometime in 2012?

A. I'm trying to remember. That was my last year on the job. Yes.

Q. What jail or prisons did you --

A. Let me just check this.

Yes. During the first month or so of 2012 I would have seen inmates.

Q. Where?

A. The State has 19 facilities. I couldn't tell you which ones I went to. I could tell you which ones I went to most commonly, but I don't have a log of where I was.

Q. Which ones did you go to most commonly?

A. I mostly commonly went to Osborn, MacDougall-Walker, York, Hartford, New Haven, and Bridgeport.

Q. Do you feel any of those facilities that you went to were similar to the facility that Mr. Poling was in that's the subject of this case?

A. I don't know --

MS. SMITH: Just object. Wait a minute, Doctor. Let me just object to form. You can answer.

THE WITNESS: I don't know very much about what this prison looks like. I will tell you that in Connecticut we have a combined prison-jail system. So some of our facilities are for unsentenced inmates or people with short sentences. Others are for sentenced people. We have the full gamut from medium security up to the highest level of security. We also have a wide variety of

medical services. Based on a person's medical or mental health classification the person might be at a facility with very few services or might be at one that has a prison infirmary with the highest level of services.

BY MR. WELLS:

Q. During the times that you provided hands-on clinical care in jail or prison facilities in Connecticut did you have occasion to request specialty care for any inmate that you may have seen?

A. I did.

Q. On how many occasions do you think you've done that?

A. I couldn't say. I should say --

Q. Was it more than five?

A. Yes.

Q. And you should say what?

A. I should say that the universe of patients that I saw was weighted richly towards those who might need specialty services because in addition to going out sometimes and taking on all comers just to provide coverage I would sometimes go specifically to a prison with the intention of seeing a particular inmate for whom specialty services had been requested either by the inmate or by the onsite staff and for whom there were outstanding questions in my mind as

to what was appropriate.

Q. So, let me just be clear. So in this those instances where you were going to see a particular inmate were you the specialty consultant that was being requested?

A. No.

Q. Okay. You were going to determine whether that further specialty care should be obtained for the patient?

A. That's correct.

Q. Okay. All right. And on the occasions where you went to see a particular patient to determine whether that patient should receive some sort of specialty care, if you thought the patient needed it what was the process that you needed to go through to get that care for the patient?

A. The process that I went through at that point would be very much like the process that any of the doctors in the facility would go through. Depending on the year and whether we had already gone electronic or were still on a paper system, I would either complete a paper request and fax it into the central office or I would sit down at a prison computer and enter the facts of the case and the rationale for the service into a system which would then be taken up to central office.

Q. And then what happens at that point?

A. At that point a small team of nurses would add information to the referral, things such as how long the